PATIENT DISPOSITION PAGE

Galesburg Cottage Hospital

Patient: SHIELDS, EARNEST
DOB: 02/19/1971 AGE: 37YRS Sex: M
EDP: BOMMIASAMY, VEERASIKKU
PCP: *NON STAFF PHYSICIAN

P#: 5290082
MR#: 000418894

DATE: 06/16/2008

Worker's Comp:
Emp. Referred:

Patient Disposition: DC - HOME ER

Acuity: 3

Presenting Complaint: *SHOULDER INJURY (MOD-SEVERE)*

PI Topics:

Discharge Diagnosis: Rotator cuff tear of left shoulder

Primary Nurse: CJS

Follow-up / Admitting Phys: STACHNIW, MYRON

Physician Consulted: No

Services Rendered: EXAM

Labels

Presentation Time: 14:57

Triage Time: 15:00

Assess: 14:58

Exam: 15:45

Initial Vital Signs

T: 97.3 PO
P: 64 regular
R: 16 unlabored
BP: 101/064
O2 100 % RA
Pain Intensity Scale: 8 / 10
Pain Location: shoulder

Discharge Vital Signs

T: 97.2 PO
P: 65 regular
R: 18 unlabored
BP: 118/072
O2 98 % RA
Pain Intensity Scale: 2 / 10
Pain Location: shoulder

Admit Ready for Room:

Disposition Date/Time: 6/16/08 19:00

Payor Type:

ER Patient: Yes

INITIAL ASSESSMENT FORM

Galesburg Cottage Hospital

PRIORITY: 3

Semi-Urgent

DATE: 06/16/2008

Patient: SHIELDS, EARNEST
DOB: 02/19/1971 AGE: 37YRS Sex: M
EDP: BOMMIASAMY, VEERASIKKU
PCP: *NON STAFF PHYSICIAN

Pt#: 5290082
MR#: 000418894
Worker's Comp:
Emp. Referred:

Presentation Time: 14:57 Triage Time: 15:00 Arrival Mode: WALK - POV

Height: 5 ' 8 " Weight: 200.0 lbs. 90.9 kgs. LMP: NA Last Tetanus: Acc By: GUARDS

Chief Complaint: SHOULDER INJURY (MOD-SEVERE)

Brief Assessment: PT. STATES THAT HE INJURED HIS LEFT SHOULDER LIFTING WAITS. WAS GIVEN TORADOL 60 MG AT HENRY HILL. HE WAS BENCH PRESSING 345 POUNDS AND HE STATES THAT THE WEIGHTS WENT BACKWARDS AGAINST HIS ARMS.

Vital Signs

T:	97.3	PO
P:	64	regular
R:	16	unlabored
BP:	101/064	
O2:	100 % RA	

Pain Intensity Scale: 8 / 10
Pain Location: shoulder

NIGHT SWEATS	NO	HEMOPTYSIS	NO
WEIGHT LOSS	NO	FEVER	NO
ANOREXIA	NO		

DOMESTIC ABUSE SUSPECTED	NO
PNEUMONIA	NO
FLU SHOT	NO
NUMBNESS	YES
DECREASED SENSATION	YES
ROM INTACT	NO
PULSE DISTAL TO INJURY ABSENT	NO
CAP REFILL > 2 SECONDS	NO

Sudden Onset:

Pre-Hospital Treatment:

Pediatric Assessment: N/A

Past Medical History: SHOT IN LOW BACK

Allergies: NONE

Medicines: NONE

Nurse Signature: Carla Sibbern RN CJS

Additional Notes:

(Includes herbals, OTC meds, vitamins, neutraceuticals)

ADMISSION

Source ☐Patient ☐Nursing Home ☐Previous Admission ☐H&P
☐Copied from Patient's Labeled Meds ☐ Patient's Pharmacy: ____________
☐Other: ____________ (name) ☐Patient Provided & Verified Medication List
Personal Meds: ☐Sent to Pharmacy ☐Sent home with ____________ (name)

DISCHARGE

If Personal Meds Stored in Pharmacy, Obtained and Sent Home With ☐Patient or ☐Other: ____________ (name)

Medication Name Dosage / Frequency / Route Patient is Knowledgeable About Home Meds: ☐Yes ☐No	Date/Time Last Taken U=Unknown T=Today Or Record Date	Continue In Hospital	Continue At Discharge	Next Dose Due At:	Reason for Medication *Verified and Teaching Sheets Provided*
NONE		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		
		☐ Yes ☐ No ____ (time) First Dose: @	☐ Yes ☐ No		

List New Medications to Be Taken

Hospital Pharmacy Order: Compare Pre-Admission Medications with Formulary Medications. Formulary medications that are identical in form and content may be dispensed for the pre-admission medications continued in the hospital, EXCEPT, do NOT dispense substitutions for the following medications: ____________

Vaccination Decision (Risk Assessment completed on admission)

☐Pneumococcal vaccine	☐Indicated	☐Not Indicated	☐Administer vaccine per protocol
☐Influenza vaccine	☐Indicated	☐Not Indicated	☐Administer vaccine per protocol

ADMISSION RECONCILIATION	DISCHARGE RECONCILIATION
Date/Time ☐READ BACK of a: ◯ Telephone ◯ Verbal Order	Date/Time ☐READ BACK of a: ◯ Telephone ◯ Verbal Order
Physician Name/Nurse Signature & Title Carla Sibben RN	Physician Name/Nurse Signature & Title
Date/Time/Ordering Physician Signature:	Date/Time/Ordering Physician Signature:
Transcribed: Date/Time/Signature/Title:	Transcribed: Date/Time/Signature/Title:
Noted: Date/Time/Admission Nurse/Title/Initials:	Noted: Date/Time/Admission Nurse/Title/Initials:

Height: 5ft. 8in.	Weight: 90.9 kg ☐ Stated ☐ Actual	Allergies: NONE

Medication Reconciliation
Galesburg Cottage Hospital

NAME: SHIELDS, EARNEST AGE: 37
MR#: 000418894 PT#: 5290082 DATE IN: 6/16/2008
EDP BOMMIASAMY, VEERASIKKU
PCP *NON STAFF PHYSICIAN
Referral Physician

Pro-MED Forms "Setting the standard in ED Automation"

Offender Name: Shields Ernest ID#: K66161

Date of medical examination: 6/16/08 Time: 1320 ☐ am ☒ pm Physician Contacted: ☒ Yes ☐ No

S (Subjective Findings): I/M [illegible] lifting [illegible] heard something pop. [illegible] severe pain (L) shoulder

O (Objective Findings):

Vitals: T 98° P 72 R 20 BP 102/78 Sat 98 Tetanus

[illegible] (L) shoulder [illegible] pain "8-10" [illegible] (L) shoulder [illegible] [illegible] capillary refill <3 [illegible] unable to [illegible] (L) shoulder [illegible] arm. [illegible]

A (Evaluation of Injury): R/O dislocation of soft tissue injury.

P (Treatment and Follow-up): (1) [illegible] 60 mg [illegible] (L) [illegible] [illegible]
(2) [illegible] x 20 min
(3) sling
(4) x-ray (L) shoulder/chest

Disposition of patient
☐ Return to assignment ☐ Housing Unit ☐ Lay in ☐ Infirmary ☐ Segregation
☐ Off-site referral for treatment (Destination)

[illegible] RN
Print Name of Person Completing Form

[signature]
Signature

[illegible]
Title

6/16/08
Date

To Be Completed By Physician

I have reviewed this report and would like to see this offender: ☐ Immediately ☐ Next Sick Call ☐ PRN

M [illegible]
Print Physician Name

[signature]
Physician's Signature

6/16/08
Date

Side 2

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0313 (Eff. 07/2006)
(Replaces DCA711-1A1)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Injury Report

Offender Name: Snuzzo Ernest ID#: R66161

Age: 34 Date of Birth: 9/19/71 Sex: M Race: Blk

Date of Injury: 6/16/08 Time of Injury: 1315 ☐am ☒pm Location: Lyon

How did the injury occur?

sleeping 34S/6S

Was it witnessed by staff? ☒ No ☐ Yes (If yes, please list names)

Location in facility:

☐ LTA (gym, basketball, football, etc.)

☐ Group (therapy)

☐ Housing Unit (cell, dayroom, tv room, etc.)

☐ School (classroom, library)

☐ Kitchen

☒ Other Lyon

Type of Injury:

☐ Sports

☐ Assault

☐ Job Related

☐ Non-Job Related

☐ Self-Inflicted

☐ Fight

Signature: [signature] Title: [illegible] Date: 6/16/06

(Medical Report on Reverse Side)

Side 1

Distribution: Offender Medical File

Printed on Recycled Paper

DOC 0313 (Eff. 07/2006)
(Replaces DC A7111-1A1)

WEXFORD HEALTH SOURCES, INC.

ILLINOIS
MEDICAL DIRECTOR QA EMERGENCY REPORTING FORM

FACILITY: Hill PHYSICIAN NAME: M. Glyburn

INMATE NAME: Shields, Earnest PHYSICIAN SIGNATURE: [signature]

DOC #: B66161 DOB: 2/19/41

TIME OF EMERGENCY EVENT

DATE: 6/16/08 TIME OF DAY: 1324

PATIENT INFORMATION

1) Medical History: Lifting weights, heard & felt a pop in shoulder & chest
GSW (L) hip + ankle

2) Current Medications:
None

3) Psych History (if applicable) ☐ Yes ☒ No:
a) When was the patient last seen by Mental Health
b) Is the patient compliant with his/her psychotropic medications:

4) Emergency Medical History Sports Injury

5) Emergency Physical Findings (pertinent PE and Lab findings):
T 98 P 72 BP 102/78 R 20 Physical Exam

PROVISION OF ONSITE EMERGENCY MEDICAL CARE

1) If the emergency occurred after hours, was the on-call physician notified? NO
) Name of on-call physician?

2) What emergency medical care was rendered? Sling, Ice, Analgesics

3) Did the patient respond to emergency treatment?

4) Why was the patient transferred to the ER? Possible shoulder dislocation

5) Is this medical condition a result of:
☒ Sports Injury ☐ Result of an altercation

DISPOSITION

1) Name of ER physician spoken to:
2) Was the patient returned to the facility?
3) Was the patient admitted to the hospital?
4) What services necessitated hospital admission?
5) Type of Transportation ___ Ambulance ___ State Vehicle ___ Air Ambulance
6) Other

Appropriateness (Completed by Wexford UM Physician):
ER Referral: Yes ___ No ___
Was referral preventable? Yes ___ No ___

This form must be submitted to Dr. Funk no later than 12 Noon EST on the next working day Fax: 312-946-3622

FAX COMPLETED FORM TO:
(412) 937-9151

WEXFORD HEALTH SOURCES, INC.

EMERGENCY / HOSPITALIZATION NOTIFICATION FORM

CORRECTIONAL FACILITY: Mill cc,

DATE: 6/16/08 REFERENCE NUMBER: B66161

INMATE NAME: Shields Earnest SSN:

INMATE NUMBER: B66161 DOB 2-19-71

ADVANCE DIRECTIVES ☐ YES ☒ NO

REFERRING PHYSICIAN

TYPE OF SERVICE:

☒ ER	☐ ADMIT THROUGH ER	☐ ER TO OBSERVATION
☐ DIRECT ADMIT	☐ HOSPITAL-TO-HOSPITAL TRANSFER	☐ SCHEDULED ADMISSION
☐ STAT LAB	☐ URGENT OFFICE	☐ URGENT RADIOLOGY/X-RAY
☐ OTHER		

FACILITY/PLACE OF SERVICE: Carlisle Hospital

ADDRESS: Gettysburg Rd 1401

TELEPHONE: 343-8131

TREATING PHYSICIAN:

TRANSPORTATION: ☐ AMBULANCE ☒ STATE VEHICLE ☐ OTHER

SPECIFIC REASON FOR EMERGENCY TREATMENT OR ADMISSION

DIAGNOSIS: R/O (L) Shoulder Dislocation

DATE OUT 6/16/08 TIME: 1415

RETURN DATE: TIME:

ADMISSION DATE: TIME:

TRANSMITTAL DATE: TIME:

BY:

AFTER HOURS NOTIFIED ☐ YES ☐ NO

Pontiac Center

☐ Reception History
☐ Periodic History

Date 7/26/08

Time: 10:35 ☐ a.m. ☐ p.m.

Offender Information:

Sheldon Earnest [illegible] ID#: B66160
Last Name First Name MI

Race: ☐ White ☑ African American ☐ Asian American ☐ Hispanic ☐ Native American ☐ Other

Gender: ☑ Male ☐ Female Date of Birth: / /

Subjective: Past Medical History / History of Present Illness / Family History

Condition	Yes	No	Family History	Explanation
Allergies		✓		
Smoking		✓		
Pediculosis		✓		
Seizures		✓		
Asthma		✓		
Cardiac/HTN		✓		
Diabetic		✓		
Communicable Disease				
a. Hepatitis/Jaundice	☐	☑		
b. Hx + PPD/Active TB	☐	☑		
c. STD	☐	☑		
d. HIV +/AIDS	☐	☑		
Surgeries	☐	☑		
Hx of Psych Tx	☐	☑		
a. Past Suicide Attempt	☐	☑		
b. Current Suicidal Ideation	☐	☑		
Recent Drug/ETOH use	☐	☑		
Mobility Problems				
a. Assistive Devices	☐	☑		
b. Prosthetics	☐	☑		
c. Specialized Equipment	☐	☑		
Other Medications		✓		
History of Sexual Abuse or Predator		✓		
Oriented x3	✓			
Other:				

Objective: T: 97.7 P: 70 ☑ regular ☐ irregular R: 18 ☑ regular ☐ irregular B/P: 122/80

Height: 5'8" Weight: 187 Vision: RT 20/ LT 20/ Corrected: RT 20/ LT 20/

Behavioral appearance and mental status, Evidence of deformity, trauma, and skin conditions, WNL

Assessment:

Plan: (Check and complete as appropriate)

1. Physical Examination: ☐ Urgent ☐ Routine
2. Mental Health Referral: ☐ Urgent ☐ Routine
3. Health Information Given: ☐ Yes ☐ Refused
4. PPD Results: ☐ Positive ☐ Negative
5. Chest X-ray performed: ☐ N/A ☐ Yes ☐ No
6. Other:

Date PPD Administered: 7/26/08 Date PPD Read: / /

Reading: ____ mm By:

K. Zehrlan
Print Name of Interviewer

Signature

R & C Use Only

LAB: Sickle Cell: ☐ Yes ☐ No Dental: Pancrex:

EKG: CXR: Female Only: PAP: Mamo:

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0092 (Eff. 9/2002)
(Replaces DC 471)

Date: 2 / 26 / 08

Time: 10:30 ☒ a.m. ☐ p.m.

Offender Information:

Last Name	First Name	MI	ID#:

Race: ☐ White ☐ African American ☐ Asian American ☐ Hispanic ☐ Native American ☐ Other____

Gender: ☐ Male ☐ Female Date of Birth: __/__/__

Objective: System	Normal	ABN	Explanation:
Head, Neck, Face, & Scalp	✓		[illegible]
Nose and Sinuses	✓		[illegible]
Mouth and Throat	✓		Oral Condition: [illegible]
Ears	✓		Drums: [illegible]
Eyes	✓		Pupils: [illegible] Fundoscopic: [illegible] Accommodation: [illegible]
Lungs and Chest Including Breast	✓		Auscultation: clear
Heart	✓		Rate: 72 /m Size: [illegible] Rhythm: [illegible] Murmurs: [illegible]
Vascular	✓		
Abdomen	✓		Consistency: [illegible] Tenderness: [illegible] Masses: [illegible] Scars: [illegible]
Anus, Rectum (Prostate – 40+ Male Only)	✓		Visual/Digital: [illegible] Guaiac +/- (R)
Genito-Urinary System	✓		[illegible]
Upper Extremities	✓		Strength/ROM: 5/5 [illegible]
Lower Extremities	✓		Strength/ROM: 5/5 [illegible]
Spine and Musculo-Skeletal	✓		
Skin and Lymphatics	✓		[illegible]
Neurologic DTR's	✓		Romberg/Biceps/Patella: [illegible]
Mental Status	✓		
Pelvis (Female Only)	✓		Cervix: Vaginal Canal: Fundus: PAP: ☐Y ☐N ☐R

Assessment: Problem # NFA

[illegible]

S/P GSW [illegible]

Plan: (Check box as appropriate and complete plan)

Placement Consideration: ☐ Yes ☒ No

HR: ☐ Yes ☒ No

Food Handler Status:

[illegible]

Examiners Signature:

Print Name	Signature	Date
[illegible] MD	[illegible]	2/26/08

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Physical Examination

Pontiac Center

Date: 2-26-08

Time: 1025 ☐ a.m. ☐ p.m.

Offender Information:

Sheridan (Last Name) Earnest (First Name) ____ (MI) ID#: B64161

Race: ☐ White ☒ African American ☐ Asian American ☐ Hispanic ☐ Native American ☐ Other____

Gender: ☒ Male ☐ Female Date of Birth: ____/____/____

	Yes	No	Explanation:
Hx reviewed	✓		
Lab reviewed	✓		[illegible]

Subjective: Condition	Yes	No	Explanation:
Allergy		✓	
Substance Abuse			
a. Alcohol	☐	☑	
b. IV Drugs	☐	☑	
c. Other Drugs	☐	☑	
d. Hx. drug/alcohol withdrawal	☐	☑	
Shared Needles		✓	
Sexual Contact with:			
a. IV drug user	☐	☑	
b. Prostitute(s)	☐	☑	
c. Multiple Partners	☐	☑	
[illegible]sexual Activity		✓	
[illegible]		✓	
HIV+/AIDS		✓	
Blood Transfusions		✓	
Three or more months of:			
a. Fever	☐	☑	
b. Diarrhea	☐	☑	
c. Night Sweats	☐	☑	
d. Persistent URI	☐	☑	
Weight Loss (>16 Lbs.)		✓	
Lymphadenopathy		✓	
Fatigue		✓	
Other (Female)			
a. Mammography	☐	☐	G____ P____ AB____ LNMP____ Date/Results:____
b. Family Hx Breast Cancer	☐	☐	If yes, family member:____
c. PAP Smear	☐	☐	Date/Results:____

[illegible] Hospitalizations:

[illegible]agnosis:____ Diagnosis:____

[illegible]te(s):____ Date(s):____

[illegible]:____ Hospital:____

[illegible]cation:____ Location:____

[illegible]ribution: Offender's Medical Record Side1 DOC 0099 (Eff. 8/2002)

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Health Status Transfer Summary

Transferring Facility: Hill Center

Offender Information: Shields (Last Name) Earnest (First Name) MI ID#: B66161

Date: 6/16/08 Time: 2:15 ☐ a.m. ☐ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: Food Handler Approved: No

Current / Acute Conditions / Problems: (L) Shoulder surgery

Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):

Acute Short-term: none

Chronic Long-term:

Chronic Psychotropic:

Current Treatments: [illegible] 60 mg [illegible] [illegible]

Therapeutic Diets: None

Follow-Up Care: (L) Shoulder

Chronic Clinics:

Specialty Referrals: [illegible]

Significant Medical History: (L) Shoulder [illegible] [illegible] 8/26/06

Physical Disabilities / Limitations:

Assistive Devices / Prosthetics: ☐ Glasses ☐ Dentures

Mental Health Issues: ☐ Hx Suicide Attempt Date: / / ☐ Hx Psych Med ☐ Hx MPC / STC Substance Abuse: ☐ Alcohol ☐ Drugs

R&C Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ NEDS ☐ MH ☐ Other ☐ Packet Complete

Tina [illegible] (Print Name and Title) [signature] (Signature) 6/16/08 (Date)

Reception Screening (completed by receiving facility health care staff):

Facility: Date: / / Time: ☐ a.m. ☐ p.m.

Subjective:

Current Complaint:

Current Medications/Treatment:

Objective:

Physical Appearance/Behavior:

Deformities: Acute/Chronic:

T: P: R: B/P: /

Assessment:

Plan: Disposition:

☐ Health Information Given ☐ Emergency Referral:

☐ Sick Call: Urgent / Routine

☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☐ Chronic Clinics

☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify):

☐ Infirmary Placement:

☐ HIV Test & Counseling Offered (only transfers from R&C)

☐ Other (specify):

Printed Name and Title Signature Date / /

For Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford to pay for it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature Date Time ☐ a.m ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility; Receiving Facility

DOC 0090 (Rev. 1/2006)

I understand that I have a right to spiritual counseling while a patient in the facility.

☐ **I DO NOT CONSENT** to the facility notifying any clergy of my presence in the facility.

(**NOTE:** I understand that if a member of the clergy identifies me by name and asks for my room / bed number, this information will be provided pursuant to the facility's *general policy on release of patient information.*)

☐ **I DO CONSENT** to the facility notifying my clergy of my presence in the facility as noted below:

Name of Clergy
Name of Church
Telephone No.

☐ **PLEASE CONTACT** the community clergy for religion _____.

(**NOTE:** If you do not have a specific clergy, the facility will contact the community clergy of the religion specified above.)

☐ **PLEASE CONTACT** the facility clergy (if applicable).

The undersigned certifies that he / she has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as his / her agent to execute the above.

Patient's Signature or Legal Representative	Date	Time
X Earnest D Shields	6-16-08	1503 ☐am ☐pm
Relationship to Patient	Interpreter, if utilized	

ADDRESSOGRAPH

SHIELDS EARNEST D
Patient #: 5290082 HSV: EOP
Adm date: 2008-06-16 Medical Rec#: 416894
Adm Dr.: BOMMIASAMY VEERASIKKU MD
DOB: 1971-02-19 Age: 37 Sex: M

ADMISSIONS
Consent for Disclosure of Information to Clergy
GALESBURG COTTAGE HOSPITAL

190-ADM-1702 1/08

WHITE – Medical Record CANARY – Person who contacts Clergy PINK - Patient

MRI I WAS CALLED FOR MRI TO BE DONE ON LEFT SHOULDER. CALLED AT 1545. MRI STATES CAN NOT BE DONE UNTIL 1800. THIS WAS CLEARED AND IT WAS OKAY. [CJS: 6/16/2008 3:41:58 PM]

Adult Assessment 06/16/2008 17:02 CJS

Room Assignment: Patient assigned to room ROOM 8. Time to room 14:58.

Psychosocial: Patient's behavior is appropriate to the current situation. Support systems include Prison guards.. Patient ambulates independently. Appears to be normally interacting with care giver(s) or others that are present. Pt. appears to be pleasant and does cooperate with staff.

Safety: Call light is within reach and patient or family was instructed on use. Bed height is at the lowest position. Patient is not at risk for fall as evidenced by: being alert and oriented at presentation, blood pressure within normal limits, no known physical impairments, no predisposing medical history, normal gait observed, < 60 years of age.

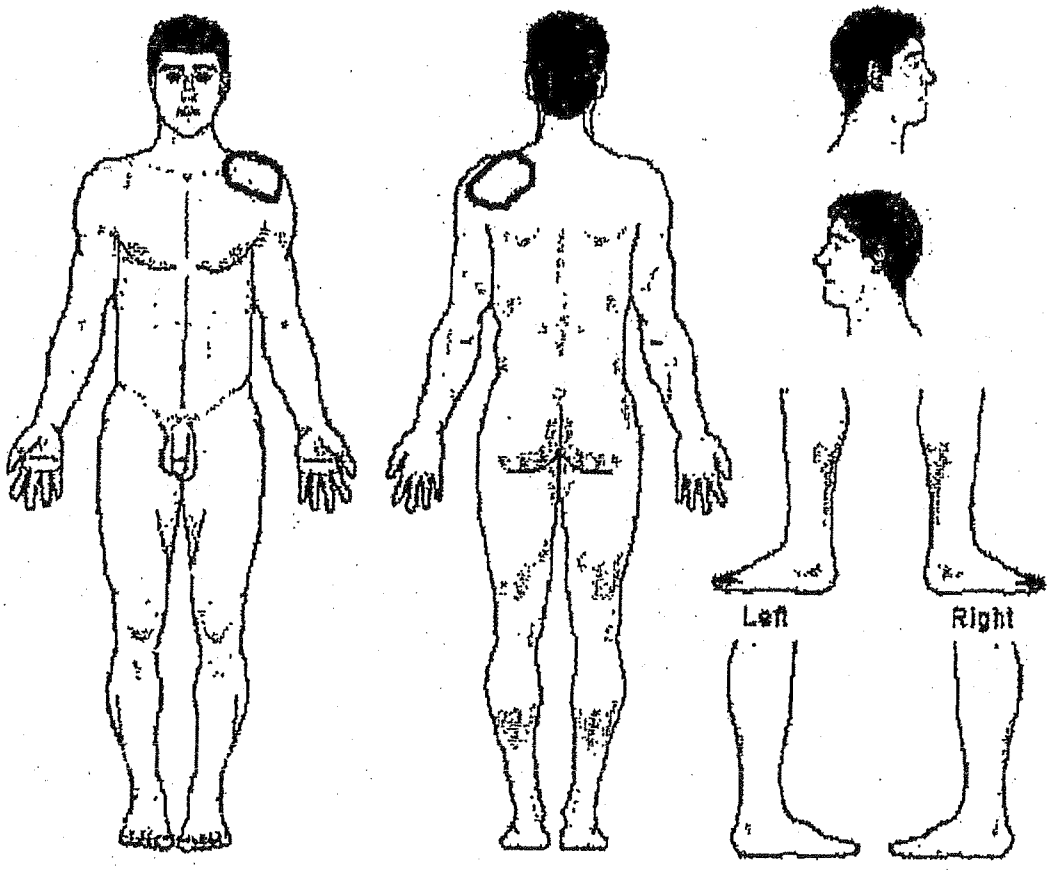
Pain: Patient rates pain as 8 on a one-to-ten scale with ten as the worst pain ever. Pain is located in the left shoulder. Patient describes the pain as sharp, throbbing, constant.

Brief Assessment: Mental Status: Patient is alert and oriented x 3.

Respiratory Status: Respirations are unlabored.

Vascular Status: Skin is warm and dry, vascular status intact.

Musculoskeletal: Patient rates pain as 8 on a one-to-ten scale with ten as the worst pain ever. Pain or injury is located where illustrated -



Pt. was lifting 375 pounds of weight while bench pressing and his shoulder went back and he injured it.

1647 PT. TAKEN TO MRI [CJS: 6/16/2008 5:02:33 PM]

Reassessment: 06/16/2008 17:00 CJS
Physician: Physician was at the bedside at 15:45. Physician seeing patient was BOMMIASAMY, VEERASIKKU.
Radiology: Patient was transported to radiology at 16:47. Patient was transferred by wheelchair.

Pt. refused Norflex stating his pain is much better. He stated he doesn't want the shot, but the he would let the nurse know if he needed the medication. [CJS: 6/16/2008 5:45:56 PM]

Reassessment: 06/16/2008 17:37 CJS
Radiology: Returned from radiology at 17:37.
Patient: Plan of care discussed with patient.
Comfort: Nourishment was offered - dinner.

Reassessment: 06/16/2008 17:56 CJS
Comfort: Nourishment was offered - ate all food given.

Flowsheets 06/16/2008 17:56 CJS

Vital Signs

Time	Temp	Route	Pulse	BP	Resp	O2 SAT	EKG	Pain Scale
17:58	97.4	PO	65	111/060	14	99	normal sinus rhythm	2

Treatments 06/16/2008 20:03 CJS

IM Dilaudid 1 mg done at 16:30 by CJS. [VEB]:

Reassessed at 06/16/2008 17:20 [CJS] - No adverse drug reaction noted. States that pain is completed relieved, and is 2 on a one-to-ten scale following the pain medicine. - CJS

Disposition 06/16/2008 20:04 CJS

Discharge: Patient left the department at 06/16/2008 19:00. Patient's disposition is: DC - HOME ER. Discharge instructions were given to the patient. The patient, person accompanying patient verbalizes understanding of the discharge instructions. The condition at discharge is improved. Vital signs taken at 18:50 were: T: 97.2 PO, P: 65 and is regular, R: 18 and unlabored, BP: 118/72, O2 Sat: 98 on RA, pain level is 2 on a 1-10 scale in the left shoulder. Pain has improved. Pt. stated that the dilaudid did "the trick" and that he did not want any other medication while here. Pain was tolerable for him.

CARLA SEBBEN RN Carla Sebben RN

ORDER PROCEDURE FORM
ORDERTHOPEDIC EMERGENCIES

Galesburg Cottage Hospital

Name: SHIELDS, EARNEST PI#:5290082
Age: 37YRS DOB:02/19/1971 Sex: M MR#:000418894
EDP: BOMMIASAMY, VEERASI PCP: *NON STAFF PHYSICIAN

Date In: 6/16/2008 Time:________

Order Time	Laboratory Tests	Order/Sent	By	Order Time	Radiology	Order/Sent	By
	CBC				CXR (PA/LAT - Portable)		
	BMP CMP						
	Sed Rate				C-Spine (X-table) (Complete)		
	Uric Acid						
	RA Factor				X-ray Lt Shoulder		
	Drug screen (serum), (urine)						
	ETOH						
	Type & Screen or Cross #___Units				Cardiopulmonary		
					EKG		
	UA				ABG		
	Beta HCG				O2 LPM		
	Misc. Orders				Medical Necessity Information:		
	Previous Medical Records						
	Physical Therapy - Eval & Tx						

Weight: lbs: 200 kgs: 90.9 Allergies: NONE

Order Time	Medication / Dosage / Route	VO	Read Back	Administered	Admin	Site	Time	Reassessment	Pain	Initials
	~~Dilaudid 2mg IM~~	☐						☐ Improved ☐ Worse ☐ Unchanged		
Pt. Refused		☐						☐ Improved ☐ Worse ☐ Unchanged		
	Norflex 60 IM	☐						☐ Improved ☐ Worse ☐ Unchanged		
		☐						☐ Improved ☐ Worse ☐ Unchanged		
	~~CJS 1745 CJS~~	☐						☐ Improved ☐ Worse ☐ Unchanged		

Order Time	IV Solution/Added Medication	Start Time Device / Size / Location / # Attempts / Amount / Start by	D/C time	Amt Infused	D/C by
	☐ KVO Device:				
	☐ IV Fluid:	Dilaudid one mg IM			
		VO Dr Bommiasamy/Hedrick			

Procedures / Nursing Assistance

☐ Cardiac Monitor Rate____ Rhythm______	☐ Splint Application	☐ (Local), (Regional) Anesthesia
☐ NIBP Monitor ☐ Pulse Oximetry	☐ Ace Bandage Application	☐ Conscious Sedation
☐ (Cold), (Heat) Application	☐ Sling Application	☐ Laceration Repair
☐ Wound Irrigation	☐ C-Spine Immobilization	☐ Cast Application
☐ Dressings	☐ Foreign Body Removal	☐ Fracture Care (open), (closed)

Discharge Instructions:

Initials/Signature: Carla Sebben RN	Initials/Signature:	Initials/Signature:	Initials/Signature:
PA/ARNP:		Physician's Signature: [signature]	

(Continued from Front)

6. **WEAPON / EXPLOSIVES / DRUGS:**
I understand and agree that if the Facility at any time believes there may be a weapon, explosive device, biohazard material, any type of illegal substance or drug, or any alcoholic beverage in my room or with my belongings, the Facility may search my room and belongings, confiscate any of the above items that are found, and dispose of them as it determines appropriate including delivery of any item to law enforcement authorities.

7. **PRIVATE ROOM DIFFERENCE (Inpatient):**
I agree and understand that if I request and receive a private room, I am responsible for the difference between the entire room rate and the semi private room rate.

8. **ADVANCE DIRECTIVE ACKNOWLEDGEMENT:**
Federal law requires that patients be provided information about their rights to make advance health care decisions, including a Living Will, Durable Medical Power of Attorney or designation of a surrogate decision maker for healthcare decisions. If you have already completed any of these documents, please inform your physician and the Facility.

Please check one:
- ☐ I have executed an advance directive and have supplied a copy to the Facility.
- ☐ I have executed an advance directive and have been requested to supply a copy to the Facility.
- ☐ I have reviewed the directive(s) on file with this Facility and it is / they are my current directive(s).
- ☐ I have not executed any advance directives, but have received information about advance directives from this Facility.
- ☐ I have not executed any advance directives, but I have requested information about advance directives from this Facility.
- ☑ I have not executed any advance directives and I do not wish to receive information about advance directives from this Facility.

9. **NOTICE OF PRIVACY PRACTICES:**
Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA) I acknowledge that I have received a copy of the Facility's Notice of Privacy Practices that provides information about how the Facility may use and disclose my protected health information.

10. **RESEARCH STUDIES:**
Please check one:
Are you currently a participant in any research study or project:
- ☑ No
- ☐ Yes *If yes, please briefly describe what is being studied (drug, medical device or other)* _____

Who can the Facility contact with questions about the study? _____

☐ Yes, I am an organ donor
☑ No, I am not an organ donor
☐ Yes, I would like to become an organ donor

11. **SMOKING CESSATION INFORMATION:**
☑ Upon admission, I received the Smoking Cessation Information Packet, which includes information on: health risks associated with smoking, community resources for smoking cessation programs and health risks associated with second hand smoke. If I have further interest in smoking cessation programs and education, I will request additional information from the facility staff or my physician.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative	Date	Time
Earnest Shields	6-16-08	1503
Relationship to Patient	Interpreter, if utilized	
Witness Signature	If Telephone Consent, Second Witness' Signature	

ADMISSIONS
Inpatient / Outpatient Conditions of Admission and Consent to Medical Treatment
ADM-1701G - Back (Rev 02/08)

Patient Label

SHIELDS EARNEST D
Patient #: 5290082 HSV EOP
Adm date: 2008-06-16 Medical Rec#: 418894
Adm Dr.: BOMMIASAMY VEERASIKKU MD
DOB: 1971-02-19 Age: 37 Sex: M

1. **GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO, AND SERVICES:**
I hereby voluntarily consent for treatment / admission to the Facility. I permit the Facility and its employees, physicians and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to with draw my consent for treatment or tests.

I consent to examinations, blood tests (including blood tests for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physicians and their associates and assistants, or rendered by Facility personnel under the instructions, orders or direction of such physician(s).

I agree and understand that all physicians, dentists, oral surgeons, and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the Facility is not responsible or liable for the acts or omissions of the aforementioned. Some services may be performed by independent contractors who are not employed by the Facility. I am aware that the practice of medicine is not an exact science and further understand that no guarantee has been or can be made as to the results of the treatments, care or examinations in the Facility.

I consent to the photographing or videotaping including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

2. **NURSING CARE:**
The Facility provides only routine nursing care. Private duty nursing is not provided but may be arranged directly between an agency and me at my expense. The Facility is hereby released from any and all liability arising from the fact that I am not provided private duty care by the Facility.

3. **PERSONAL VALUABLES:**
I understand that the Facility maintains a safe for the safekeeping of money and valuables, and the Facility shall not be liable for the loss or damage to any articles of personal property unless said articles are deposited with the Facility in the safe and receipts are issued describing said items. At no time shall Facility be responsible for more than $500 for said deposited items.

4. **ASSIGNMENT OF INSURANCE BENEFITS / PROMISE TO PAY:**
I hereby assign and authorize payment directly to the Facility, and to any facility-based physician, all insurance benefits, sick benefits, injury benefits due because of liability of a third-party, or proceeds of all claims resulting from the liability of a third party, payable by any party, organization, et cetera, to or for the patient unless the account for this Facility, outpatient visit or series of outpatient visits is paid in full upon discharge or upon completion of the outpatient series. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I under stand that I am responsible for any charges not covered by my insurance company.

I understand that I am obligated to pay the account of the Facility in accordance with the regular rates and terms of the Facility. If I fail to make payment when due and the account becomes delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney's fees. I also agree that any patient or guarantor overpayments on the above Facility visit may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment.

5. **EMTALA:**
The Facility is obligated to treat medical emergencies regardless of my ability to pay. Therefore, if I or my guarantor have a medical emergency or if I am a pregnant woman in labor, I have the right to receive, within the capabilities of this Hospital's staff and facilities, an appropriate medical screening examination, necessary stabilizing treatment, and, if medically necessary, an appropriate transfer to another hospital, even if I cannot pay or do not have medical insurance or am not eligible to receive Medicare or Medicaid.

(Continued on Back)

ADMISSIONS
Inpatient / Outpatient Conditions of Admission and Consent to Medical Treatment
ADM-1701G - Front (Rev 02/08)

Patient Label

SHIELDS EARNEST D
Patient #: 8290002 HSV: EOP
Adm date: 2008-06-16 Medical Rec#: 416884
Adm Dr.: BOMMIASAMY VEERASIKKU MD
DOB: 1971-02-19 Age: 37 Sex: M

WEXFORD HEALTH SOURCES, INC.

ILLINOIS
MEDICAL DIRECTOR QA EMERGENCY REPORTING FORM

FACILITY: Hill PHYSICIAN NAME: [illegible]

INMATE NAME: Shields, Earnest PHYSICIAN SIGNATURE: [illegible]

DOC #: B66161 DOB: 2/19/71

TIME OF EMERGENCY EVENT

DATE: 6/16/08 TIME OF DAY: 1324

PATIENT INFORMATION

1) Medical History: Lifting weights, heard + felt a pop in shoulder & chest. GSW (L) foot + ankle

2) Current Medications: None

3) Psych History (if applicable) ☐ Yes ☒ No:
   a) When was the patient last seen by Mental Health
   b) Is the patient compliant with his/her psychotropic medications:

4) Emergency Medical History: Sports Injury

5) Emergency Physical Findings (pertinent PE and Lab findings):
   T 98 P 72 BP 102/78 R 20 Physical Exam

PROVISION OF ONSITE EMERGENCY MEDICAL CARE

1) If the emergency occurred after hours, was the on-call physician notified? N/A
   Name of on-call physician?
2) What emergency medical care was rendered? Sling, Ice, Analgesics
3) Did the patient respond to emergency treatment?
4) Why was the patient transferred to the ER? Possible shoulder dislocation
5) Is this medical condition a result of:
   ☒ Sports Injury ☐ Result of an altercation

DISPOSITION

1) Name of ER physician spoken to:
2) Was the patient returned to the facility?
3) Was the patient admitted to the hospital?
4) What services necessitated hospital admission?
5) Type of Transportation ___ Ambulance ___ State Vehicle ___ Air Ambulance
6) Other

Appropriateness (Completed by Wexford UM Physician):
ER Referral: Yes ______ No ______
Was referral preventable? Yes ______ No ______

This form must be submitted to Dr. Funk
no later than 12 Noon EST on the next working day
Fax: 312-845-3622

Illinois
Department of
Corrections

Rod R. Blagojevich
Governor

Roger E. Walker Jr.
Director

Hill Correctional Center / 600 Linwood Road / P.O. Box 1327 / Galesburg, IL 61401 / Telephone: (309) 343-4212 / TDD: (800) 526-0844

MEMORANDUM

DATE: August 19, 2008

TO: Infirmary Staff

FROM: Lois Mathes, RN/HCUA

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Earnest IDOC#: B66161 D.O.B: 2-19-71
DATE: 8-26-08 LEAVE TIME: 6:15a.m.

REFERRING PHYSICIAN: Dr. Miglorino/Dr. Funk
REASON FOR FURLOUGH: Ortho. Eval. (Pectoralis Tendon Rupture Left Shoulder).

LOCATION: Dr. Olysav's Office
STREET: 747 N. Rutledge/Baylis Building 5th Floor
CITY/STATE/ZIP: Springfield, IL 62703
TELEPHONE NUMBER: (217) 545-5878

SAME DAY RETURN: X ADMISSION: EMERGENCY:
AMBULANCE:

1. Complete HS Report – Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

Prep Needed: **Bring copies of all reports and x-ray film to appt. that is pertaining to problem.**

Cc: Records Office
7/3 Shift Commanders
Medical File
X-Ray
File

Illinois
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Corrections

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Governor

Roger E. Walker Jr.
Director

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MEMORANDUM

DATE: October 15, 2008

TO: Infirmary Staff

FROM: Lois Lindorff, RN/HCUA

New Doctor + Time

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Earnest NUMBER: B66161 D.O.B.- 2/19/71
DATE: 10/22/08 LEAVE TIME: 7:45 a.m.

PHYSICIAN: Dr. Miglorino/Dr. Funk
REASON FOR FURLOUGH: 2nd Visit for Physical Therapy.

LOCATION: Cottage Rehab & Physical Therapy
STREET: 765 N. Kellogg Street/ Suite 300
CITY/STATE/ZIP: Galesburg, IL 61401
PHONE NUMBER: (309) 343-3434

SAME DAY RETURN: X ADMISSION: EMERGENCY:
AMBULANCE:

1. Complete HS Report – Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

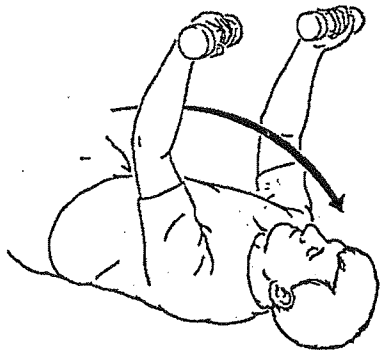
Prep Needed: **None.**

Cc: 7/3 Shift Commanders
Records Office
x-ray
medical file
file

Routine For: Ernest Shields
Created By: Cottage Rehab & SM Physical Therapy

Oct 09, 2008

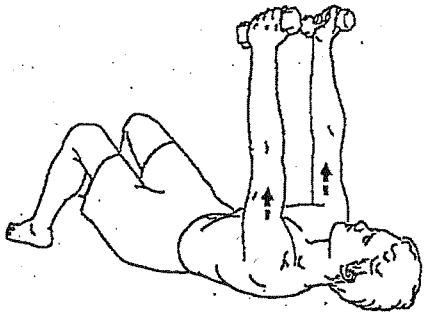
SHOULDER - 63 Progressive Resisted: Flexion (Supine)



Holding 0-1 pound weight, raise your left arm over head and lower toward floor. Go as far as possible without pain.

Repeat 20 times per set. Do 2 sets per session.
Do 1-2 sessions per day.

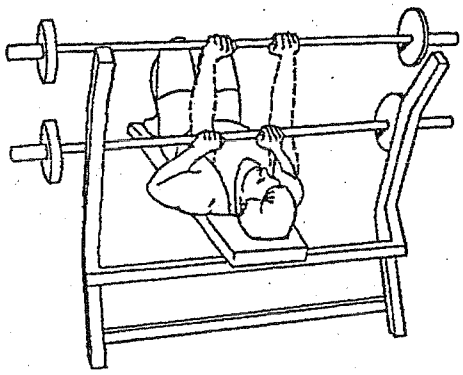
SHOULDER - 57 Scapular: Protraction – 90° of Flexion



Holding 0-5 pound weights, attempt to push arms up toward ceiling, keeping elbows straight and back against floor.

Repeat 20 times per set. Do 2 sets per session.
Do 1 sessions per day.

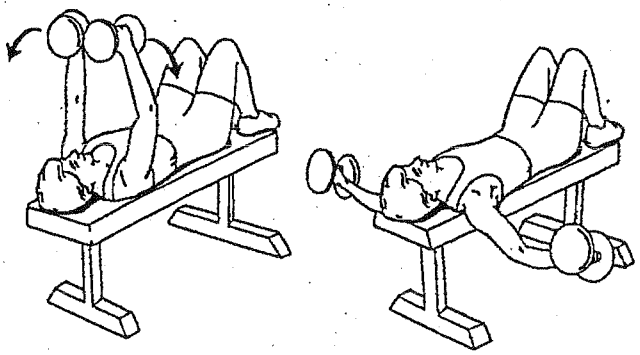
CHEST - 20 Bench Press: Narrow Grip (Barbell)



With a stick or cane in both hands, press up as in doing a bench press.

Do 2 sets. Complete 20 repetitions. Do 1-2 times per day.

CHEST - 12 Fly (Dumbbell)



Lower arms out to the side as far as comfortable and then back up.

Do 2 sets. Complete 20 repetitions. Do 1-2 sessions per day.

ICE: 15 MINUTES ON, 1 HOUR OFF

AS NEEDED FOR PAIN RELIEF AND SWELLING

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Director

Hill Correctional Center / 600 Linwood Road / P.O. Box 1327 / Galesburg, IL 61401 / Telephone: (309) 343-4212 / TDD: (800) 526-0844

MEMORANDUM

DATE: October 6, 2008

TO: Infirmary Staff

FROM: Lois Lindorff, RN/HCUA

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Earnest NUMBER: B66161 D.O.B.- 2/19/73
DATE: 10/9/08 LEAVE TIME: 8:30a.m.

REFERRING PHYSICIAN: Dr. Miglorino/Dr. Funk
REASON FOR FURLOUGH: Physical Therapy (1st visit).

LOCATION: Cottage Rehab & Physical Therapy
STREET: 765 N. Kellogg Street/Suite 300
CITY/STATE/ZIP: Galesburg, Il 61401
PHONE NUMBER: (309) 343-3434

SAME DAY RETURN: X ADMISSION: EMERGENCY:
AMBULANCE:

1. Complete HS Report – Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

Prep Needed: None.

Cc: 7/3 Shift Commanders
Records Office
x-ray
medical file
file

DOS: 08/26/08 PV: DO340
MR#: 820246
PT: EARNEST SHIELDS
DOB: 02/19/1971

Subject: [Fwd: [Fwd: Wexford Health Sources]]
From: Lynn Singleton <lsingleton@siumed.edu>
Date: Fri, 22 Aug 2008 10:45:37 -0500
To: Janice Herman <jherman@siumed.edu>

-------- Original Message --------
Subject: [Fwd: Wexford Health Sources]
Date: Tue, 19 Aug 2008 09:22:37 -0500
From: Judie Riech <jriech@siumed.edu>
To: Lynn Singleton <lsingleton@siumed.edu>

Lynn -- Forwarding e-mail sent to you last Friday. Just received a call from the Call Center saying they did not have authorization to make this appointment and transferred the call to me. Can you rectify? I have confirmed approval with correctional center for EARNEST SHIELDS, #B-66161 and asked them to call the CALL CENTER back in 30 minutes.
Thank you,
-------- Original Message --------
Subject: Wexford Health Sources
Date: Fri, 15 Aug 2008 15:53:20 -0500
From: Judie Riech <jriech@siumed.edu>
To: Lynn Singleton <lsingleton@siumed.edu>, Cheryl McGill <cmcgill@siumed.edu>

SIU P&S has signed an agreement to provide medically necessary and authorized evaluation, treatment, and follow up care for the following:

Earnest Shields -- #B-66161 -- by Orthopaedic Surgery -- for Pectoralis Rupture

Original agreement is being forwarded to Patient Billing Services

Thank you,
Judie Riech
SIU P&S Admin. Office
545-8850

EARNEST SHIELDS 4212373	MRN #: 820246	Home: (309)999-9999	Office: (309)343-
39 Years Old Male (DOB: 02/19/1971)	452216-2155001	Ins: WEXFORD (W25)	

09/12/2008 - Phone Note
Provider: David J Olysav, MD
Location of Care: SIU HealthCare

Ok for PT to instruct 2-3 times for home PT per Dr. Olysav

Rx and note faxed to Natalie.

---- Converted from flag ----
---- 09/05/2008 4:25 PM, Katherine McMullin wrote:
Returned call and they had left already will return call again Monday am

---- 09/04/2008 2:08 PM, Katherine McMullin wrote:

---- 09/04/2008 1:55 PM, Beth Ann Peters wrote:
Is it for one time or does he have to go 2 to 3 times a week. Please call back by tomorrow. they need to know because he has collegial. Please call Natalie w/ Henry Hill Correction Center at 309-343-4212 ext 373 and she leaves at 4. Thanks

Clinical Lists Changes

Signed by Katherine McMullin on 09/12/2008 at 4:37 PM
Signed by David J Olysav, MD on 09/16/2008 at 7:57 AM

EARNEST SHIELDS 4212373	MRN #: 820246	Home: (309)999-9999	Office: (309)343-
39 Years Old Male (DOB: 02/19/1971)	452216-2155001	Ins: WEXFORD (W25)	

08/26/2008 - Transcription: EMDAT Clinic Note
Provider: John Froelich, M.D.
Location of Care: SIU HealthCare

EMDAT Clinic Note

CHIEF COMPLAINT: Left pectoralis major rupture.

HISTORY OF PRESENT ILLNESS: This is a 37-year-old gentleman who is a member of the Corrections Institution who was bench pressing on June 18, 2008, felt a sudden pain in his left arm and had a audible popping sound. Noted some numbness in his arm. He was evaluated in the local emergency room. Then MRI of the shoulder showed no significant injury other than a mild supraspinatus tear per a written documentation as the MRI is not here. He states that he continues to have numbness and night pain as well as discomfort. He had seen orthopedic surgeons who said they would not treat this injury on him. The patient is here for another opinion. He has not been doing any physical therapy or activity. He has been using a sling for sometime.

PAST MEDICAL HISTORY: History of meningitis as a child.

PAST SURGICAL HISTORY:
1. Repair of the left ankle after GSW.
2. History of multiple spinal taps.

MEDICATIONS: None.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

SOCIAL HISTORY: He is currently under the correctional system. Denies use of tobacco.

PHYSICAL EXAMINATION:
General: The patient is in no acute distress. Answers questions appropriately. Alert and oriented and appears stated age.
HEENT: Normocephalic, atraumatic. Gross extraocular movements are intact.
Cardiovascular: Regular.
Pulmonary: Unlabored.
Abdomen: Soft.
Musculoskeletal: Examination of the left shoulder shows no tenderness to palpation of the AC joint, the distal acromion, or the anterior biceps. He has forward flexion of 90 degrees active, passive 130 degrees, abduction active 75 degrees, passive 110 degrees, external 25 degrees active with 5-/5 strength. He has 5/5 strength to the supraspinatus and 5-/5 internal rotation. He is unable to get his arm to the back pocket position.
Digital examination of the shoulder shows palpable and visual defect in the pectoralis distribution. He is tender to palpation over the anterior chest with retraction of the pectoralis. When the patient does internally rotate the pectoralis does fire on his chest but in view there is a obvious palpable and visual defect and it does not insert on to the humerus at this time. There is no excessive swelling on that

EARNEST SHIELDS 4212373	MRN #: 820246	Home: (309)999-9999 Office: (309)343-
39 Years Old Male (DOB: 02/19/1971)	452216-2155001	Ins: WEXFORD (W25)

side versus the right.

IMAGING: MRI is not obtainable in the office today. The patient has plain films of the arm. Two views of the shoulder AP and oblique which show no fracture noted.

ASSESSMENT AND PLAN: This is a 37-year-old gentleman with a ruptured left pectoralis major. At this time, we will encourage the patient to do aggressive PT with strengthening as he has deconditioned the area as well as has lost range of motion in that arm.

Electronically Signed By:
John M. Froelich, M.D.

Resident

The following text was appended to the transcription:
I saw and personally examined the patient and discussed the case with the resident. I have reviewed the resident's note and agree with the content and plan as written except as follows: none.

Electronically Signed By:
David J. Olysav, M.D.

Associate Professor of Clinical Surgery

Signed before Import by John Froelich, M.D.
Filed automatically on 09/02/2008 at 12:08 PM